STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearings No. 18,289,
	)	18,334,
Appeal of	)	18,405,
	)	18,451,
	)	18,457,
	)	18,496,
	)	18,497,
	)	& 18,616
	)	

INTRODUCTION

The petitioners (whose cases have been consolidated pursuant to Fair Hearing Rule No. 21) appeal the decisions by the Department of Aging and Disabilities (DAD) reducing the hourly levels of personal care services that each received under the Medicaid Home and Community Based Waiver Services Program starting in the year 2003. The petitioners allege that changes in the Department's policies regarding determinations of allocations of services violated the Vermont Administrative Procedures Act (APA) in that they were not promulgated pursuant to statutory rulemaking public notice and comment. The petitioners also allege that the Department violated their due process rights by reducing their hours without sufficient advance personal written notice and by not continuing their allotted hours at their 2002 levels prior to their cases being decided on appeal. Further, they allege that

the Department's policies are contrary to the terms of Vermont's federal Medicaid Waiver. The following facts are not in dispute.

FINDINGS OF FACT

1. The petitioners have been recipients of Medicaid Waiver services in their homes for several years. There is no issue in this matter that any of the petitioners' medical conditions or levels of functioning had significantly improved when their cases were reviewed by the Department in 2003.

2. The Medicaid Waiver program is administered by DAD, which evaluates initial and continuing eligibility for the program and also determines the level of services for each eligible recipient. The underlying purpose of the program is to provide in-home personal care services as an alternative to institutionalized nursing home care.

3. Pursuant to the terms of the waiver that governs the administration of the program in Vermont, DAD conducts an annual assessment of each participant through the formulation of a written individualized **Plan of Care**. These assessments are usually done in the home of the recipient by a trained case manager, who is usually a registered nurse. This individual fills out a **Personal Care Worksheet** in consultation

with the recipient and/or the recipient's family and/or caregivers. DAD then reviews each worksheet and authorizes payment to the providers of the service in accordance with the number of hours that have been approved for each service under the individual's **Plan of Care**.

4. The types of services covered under the Medicaid Waiver program are divided into two categories, activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLS are dressing, bathing, grooming, bed mobility, toileting, continence/bladder & bowel, adaptive services, transferring, mobility, and eating. IADLs are phone use, meal preparation, medication, money management, heavy housekeeping, light housekeeping, shopping, travel assistance, and care of adaptive equipment.

5. Prior to the annual reviews of their cases that occurred in 2003, each of the petitioners had for several years been routinely approved for the level of personal care services that had been requested on each one's yearly **Personal Care Worksheet**.

6. The worksheets in effect prior to 2003 contained "guidelines" for each ADL and IADL, but in most cases DAD admits that it routinely approved the level of service actually requested.

7. In early 2003, as part of a deficit reduction strategy[1], DAD implemented revisions in its worksheets and procedures to correct "inequities" that DAD admits had developed in the program statewide. The major change was to place "maximums" on the amount of time allowed for each ADL and IADL on the worksheet, and to require each recipient to request a "variance" for any requested service hours above the maximums. Variances would be granted whenever a recipient's "health and welfare" would be at risk by adhering to the maximums. DAD represents that the purpose of the change in its forms was to make decisions statewide more uniform and to base them on each individual's actual medical need as opposed to lifestyle and/or personal preferences and habits, thus saving money for the program by eliminating service hours that weren't medically necessary.

8. Although its actions appear to have been primarily driven by budgetary concerns, DAD represents that the changes in its worksheet resulted in a majority of Medicaid Waiver recipients statewide being approved for either the same level of service or an increase over what they had received the year

[1] At the time, DAD was projecting a shortfall of two million dollars in the Medicaid Waiver program for fiscal year 2003.

before. Unfortunately, this was not the case with the petitioners herein.

9. At varying times during 2003, depending on the month of their scheduled annual reviews, each of these petitioners' case managers submitted a **Personal Care Worksheet** for the next one-year period. It appears that in some of these petitioners' cases the 2003 worksheets submitted by their case managers requested the same or nearly the same total number of hours per week of services that had been requested and approved the year before. However, because of the newly imposed maximums on each type of service, these petitioners had to request "waivers" in some areas of service to maintain the same level of service they had received the year before. For the other petitioners, it appears that their case managers initially did not request any level of service that was above the maximums, even though this resulted in a lower level of requested service from the year before.

10. Following each petitioner's appeal of the reduction in his or her overall hours, the Department's Independent Living Consultant conducted a review of each petitioner's request for waivers in one or more service areas, and in June 2003 she issued a new **Plan of Care** for each of them. These decisions resulted in revisions in the number of hours for

some of the petitioners (i.e., some waiver requests were granted in whole or in part), but it left all of them with varying decreases in the overall number of weekly hours from what each had received the year before.

11. All of the petitioners were then offered a "Commissioner's review" of these decisions. In September 2003 the Commissioner issued review decisions that essentially affirmed the consultant's **Plan of Care** determinations. During the pendency of this process (but not thereafter) the Department continued each petitioner's level of Medicaid Waiver services at the 2002 levels.

12. Despite the hearing officer continuing these cases expressly for this purpose, only two of the named petitioners in this matter (Fair Hearing Nos. 18, 334 and 18,457) requested further review by the Human Services Board of the factual bases of their 2003 care plans as determined by the Department. The hearings in these two cases were not completed until June 2004. In recommendations that are separately pending before the Board at this time the hearing officer has found that neither of these two petitioners has shown sufficient medical evidence to overturn the Department's decisions denying their requests for waivers.

13. The upshot of the above paragraph is that all but two of the named petitioners in this matter do not challenge the *factual* bases of the Department's 2003 determinations in their cases. In effect, *they have conceded that the Department's June 2003 Plan of Care decisions were appropriate to their actual medical needs*. And the two who did challenge the factual bases of their Plans of Care have been unsuccessful (at least to date) in overturning or revising the Department's decisions in their cases. Thus, all the petitioners herein are left only with a *procedural* basis for the "relief" they are now seeking--i.e. reinstatement of their personal care hours to 2002 levels.

14. Although it vigorously defends the *legality* of its actions in this regard, the Department does not dispute the *facts* that it did not follow the APA when it implemented the changes in its procedures in 2003 and that it did not provide any recipient of Medicaid Waiver services with advance written notification that it would be using revised worksheets to determine plans of care. The Department also admits that it did not continue any petitioner's services at 2002 levels beyond its Commissioner's review decisions in September 2003.

15. The above notwithstanding, it does not appear that the petitioners in this matter allege any actual disagreement

with the 2003 changes in Department policy. They allege only that the Department failed to provide public notice and elicit public comment before implementing the changes. Although directly queried by the hearing officer in this regard, the petitioners have not pointed to anything in the new procedures they would change as a matter of fairness or public policy.[2]

ORDER

The Department's decisions are affirmed.

DISCUSSION

At the outset, the Department's argument that the Board lacks jurisdiction to even consider the petitioners' procedural claims must be summarily rejected. See *In re Diel*, 158 Vt. 549 (1992). However, this does not mean that the Board is *required* to consider the petitioners' claims as a matter of law. 3 V.S.A. § 3091(d) provides, in part (with emphasis added):

> After the fair hearing the board *may* affirm, modify or reverse decisions of the agency . . . and it *may* make orders consistent with this title requiring the agency to

[2] The only argument they have made is at best a half-hearted one, that *perhaps* the Department could have chosen to "grandfather" all existing Medicaid waiver recipients before making the changes. However, given the uncontested fact that the changes were primarily intended to avoid an immediate critical budget shortfall, it is difficult to see the logic of exempting virtually everyone in the program from such changes, even for a limited period of time.

> provide *appropriate relief* including retroactive and prospective benefits . . .

For purposes of this decision it will be assumed *arguendo* that (but not actually considered whether) the legal bases of the petitioners' arguments are correct--i.e. that the Department was required to follow the APA when it was considering changes in its policies, that the Department was required to give all recipients advance written notice of those changes, that the Department failed to follow Vermont's federal Medicaid Waiver, and that the Department was required to continue the benefits of any recipient who requested an appeal of any resulting reduction in his or her hours of Medicaid Waiver Services. However, given the facts and the procedural histories of these cases, it cannot be concluded that any further "relief" is "appropriate" for any of these petitioners, either as a matter of law or as a matter of fundamental fairness.

The federal statutes and regulations governing the Medicaid Waiver program allow states considerable latitude and discretion in determining eligibility and levels of service. See 42 U.S.C. § 1396n(c). Unlike many other benefit programs, *initial* eligibility for Medicaid Waiver services is not an entitlement. The amount of funding for the program is fixed

on an annual basis. Participating states are allowed to maintain (and Vermont does so maintain) waiting lists of otherwise eligible individuals due to limited levels of funding. See *Boulet v. Celluci*, 107 F.Supp.2d 61 (D.Mass., 2000).

Given the limited nature of the funding for this program and the recognition that it cannot serve many eligible individuals, it is entirely reasonable, and arguably imperative, especially in periods of budget crises, for DAD to attempt to ensure that program funds are distributed fairly and equitably among those who have been found eligible for services. In this case, DAD candidly admits that for several years it placed too much reliance on individual case managers to render uniform assessments of the needs of recipients statewide. The Department admits that before 2003 it did not carefully review individual personal care worksheets to determine whether the hours being requested for each ADL and IADL were truly necessary in light of each recipient's medical condition. The Department maintains, *and the petitioners herein do not dispute*, that its new policy of imposing maximums on the levels of each service, and the necessity of requesting waivers to exceed those maximums, is reasonably

intended and likely to obtain more statewide oversight and uniformity in the provision of those services.

The Department further maintains, *and the petitioners do not dispute*, that its maximums are based on the generous assessments of medical experts as to the time necessary to perform each covered ADL and IADL for most individuals who require assistance in those areas. Recognizing, however, that individual needs may vary from recipient to recipient based on individual medical considerations, the Department allows, and clearly advises, all recipients to request a waiver of the maximums to obtain the level of service for any ADL or IADL that they feel is necessary and appropriate. In keeping with the purposes of the program and with its goal of statewide uniformity, DAD makes each waiver determination in light of a recipient's demonstrated medical need, rather than on the basis of individual lifestyle or habit. *Again, the petitioners do not contest the wisdom and fairness of this procedure, or that the Department made it fully available to them in the course of these proceedings*.

The Department admits that its new policy resulted in decreases in levels of service for many recipients, including the petitioners herein. However, given the lack of evidence (or, in all but two of these cases, even the *claim*) that

anyone's medical needs are going unmet, both parties are forced to concede that the petitioners for many years prior to 2003 all received levels of service that were not truly commensurate with their medical needs. Now, *solely* on the basis of alleged procedural deficiencies in the Department's implementation of the 2003 policy revisions, the petitioner's are, in effect, asking the Board to grant them the "relief" of continuing to receive more hours of service than their medical conditions warrant, at least in comparison with everyone else in the program. Regardless of the "merits" of the petitioners' legal arguments, the hearing officer concludes that such relief is neither required nor appropriate under the board's statutes and regulations.

Each petitioner in this matter appears to have received at least some level of continuing benefits until September 2003 when the Department completed a full and detailed review of each of their requests for waivers under the new procedures. Only two of the petitioners even appealed the Department's final decision in this regard to the Board, and it has been recommended by this hearing officer that the Department be affirmed in those two cases. In light of the above, if it were to be concluded that the petitioners herein were "entitled" to a further continuation of their 2002

benefit levels solely on the basis of the procedural defects they allege, this would mean that *every* Medicaid Waiver recipient whose hours were reduced in this manner (a number that may well be in the hundreds) would be similarly entitled. Arguably, due process and equal protection considerations would then force the Department to reinstate their benefits as well. The result could well be that hundreds of recipients could see their levels of service reinstated to a level *above their presently demonstrated medical need*. Due to the limited nature of the funding for this program (discussed above), these recipients' "relief", by necessity, could only come at the expense of the many needy applicants currently on the Department's waiting list for future coverage.

The above considerations argue forcefully that the Board defer such technical questions of *procedural* entitlement to a court of competent jurisdiction that (unlike the Board) is empowered to grant *class action* relief to *all* those recipients with potential claims identical to those of the petitioners herein. If, upon reflection, any or all of the petitioners in this matter continue to consider themselves entitled to further relief, they are free to pursue this remedy. However, given the unique nature of the Medicaid waiver program, and the lack of any claimed or demonstrated "inequity" in these

petitioners' present situations, the Board affirms the Department's decisions in these cases.

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